

**Department of Employee Trust Funds  
Local Health Insurance Administration Manual**

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## **Chapter 10 — Retirement, Disability or Long-Term Disability Insurance**

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## **1001 Coverage – Requirements to Continue**

Coverage under the State Group Health Insurance Program may be continued when an employee is eligible for a retirement benefit or applies for a Wisconsin Retirement System disability or Long-Term Disability Insurance (LTDI) benefit upon termination of employment. In addition, subscribers and their insured dependents who are continuing coverage must enroll in Medicare Parts A and B when first eligible. This is required by state statute, as the State Group Health Insurance Program is designed to integrate with, rather than duplicate, Medicare benefits. The group health insurance coverage will be converted to a plan that is integrated with Medicare effective on the first of the month in which the member is required to be enrolled in Medicare. The amount of the monthly premium will be reduced accordingly. Retrospective adjustments to premiums are limited to the shortest retroactive enrollment limit set by Medicare (90 days), in accordance with the WPE Group Health Insurance Program contract.

**Note:** Active employees (non-annuitants) reported on the monthly invoices are not required to enroll in Medicare when first eligible and do not receive the Medicare reduced premium rate in the event they do enroll in Medicare.

- **Retirement Benefit**

Group health insurance coverage will automatically be continued if the employee retires on an *immediate annuity*. An immediate annuity is defined as a benefit that begins within 30 days after the employee terminates employment. This benefit can be a monthly benefit or a lump sum annuity.

Health insurance coverage automatically continues for covered employees upon retirement. If the retiring employee does not wish to continue health insurance coverage after retirement and wants to cancel coverage, ***ETF must receive that notification in writing with the member's signature PRIOR to their active employee coverage ending.*** A *Verification of Health Insurance Coverage and Local Employer Paid Annuitant Transfer Report (ET-4814)* must be submitted to ETF, signed by both employer and employee, indicating whether the employee elects to continue or cancel health coverage.

- **Disability or LTDI Benefit**

Insured employees applying for a WRS disability or LTDI benefits must pre-pay premiums through their employers until their WRS disability or LTDI benefit is approved by ETF, or else coverage will lapse.

Employees who are on an unpaid leave of absence immediately prior to termination, and whose coverage has lapsed due to non-payment of premiums, can reinstate coverage if an immediate WRS disability or LTDI benefit is taken. Once the WRS disability or LTDI benefit is approved, ETF will send the employee a letter and a *Health Insurance Application/Change Form* (ET-2301) offering lifetime coverage under the State Group Health Insurance Program. The *Health Insurance Application/Change Form* must be received by the deadline provided in the letter (30 days from the date of the letter). ETF will notify the employer when a disability or LTDI benefit is approved. The employer will then need to terminate the employee from active coverage. (Refer to Chapter 8.)

- **Termination with 20 Years of WRS Service; Not Taking Immediate Annuity**

Group coverage can be continued when terminating after age 55 (50 for protective category employees) when the employee has at least 20 years of WRS creditable service, even if an immediate retirement annuity is not taken. The employee completes and submits a *Continuation – Conversion Notice* (ET-2311) to ETF at the time of the employee's termination. (Refer to Chapter 9.) The employee will be billed by the health plan for their coverage.

## 1002 Medicare Enrollment

Active employees and their insured dependents eligible for coverage under the Federal Medicare program may defer enrollment under Medicare Part A (hospital) and Part B (medical) until the employee terminates employment or health insurance coverage as an active employee ceases.

Annuitants and insured dependents who are eligible for coverage under the Federal Medicare program must enroll in Parts A and B when first eligible due to age or disability per Wis. Stats. § 40.51(7) and 40.52(2). Annuitants and insured dependents failing to enroll in Medicare will be held responsible for the portion of claims that Medicare would have covered, had they been enrolled in Medicare. Failure to enroll in Medicare at the next enrollment opportunity may result in termination of coverage in the WPE Group Health Insurance program.

A *Medicare Eligibility Statement* (ET-4307) is used to inform ETF of the Medicare effective dates. ETF will mail the Medicare Eligibility Statement to the retiree for completion. A sample of the Medicare Eligibility Statement appears at the end of this subchapter. Please provide ETF with a copy of the retiree's Medicare card, when available.

## Medicare Eligibility Statement (ET-4307)



### Medicare Eligibility Statement

Wis. Stat. §§ 40.51 (7) and 40.52 (2)

Wisconsin Department  
 of Employee Trust Funds  
 801 W Badger Road  
 PO Box 7931  
 Madison WI 53707-7931

1-877-533-5020 (toll free)  
 Fax 608-267-4549  
 etf.wi.gov

Make a copy for your records and return the original by mail or fax to ETF.

Subscriber Information <i>Please print clearly</i>	
Subscriber name – Policy holder (first, middle, last)	Member ID or SSN
Mailing address (Street or PO Box, city, state, ZIP code)	<input type="checkbox"/> Check this box if this is a change of address.
Indicate the reason you are now eligible for Medicare: <input type="checkbox"/> Age 65 and over <input type="checkbox"/> Receipt of Social Security disability payments for 24 months <input type="checkbox"/> End Stage Renal Disease (ESRD) <input type="checkbox"/> Lou Gehrig's Disease (ALS)	

Prescription Drug Coverage
Prescription drug coverage in this program is provided by Navitus MedicareRX (PDP), a Medicare Part D Employer Group Waiver Plan.
Do you have other prescription drug coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, plan name: _____
Since you may only have one Part D plan, please select which plan you want to use: <input type="checkbox"/> Navitus MedicareRX (PDP) <input type="checkbox"/> Your current Part D plan
Attach a copy of your Medicare card or documentation from Medicare that clearly states your Medicare claim numbers and effective dates. <b>If you have not yet received your card reflecting your Parts A and B coverage, contact the Social Security Administration to obtain your information, and return this completed form to ETF as soon as possible. Send a copy of your card to ETF once you receive it.</b>

Persons Insured Under Your Group Health Insurance Policy				
Complete the table with the names and birth dates of all persons on your group health insurance policy. List effective dates and claim numbers or write "not eligible" if not eligible for Medicare. Include yourself as the subscriber, as well as spouse or domestic partner, and any dependents. See Page 2 for how to read your Medicare card.				
Names	Birth date	Medicare claim number	Medicare effective dates as shown on card	
			Hospital (Part A)	Medical (Part B)

By signing this statement, I attest that I have read and understand the <b>Important Medicare Information on Page 2</b> , the information I provided above is true and correct to the best of my knowledge and I authorize the Department of Employee Trust Funds to verify information regarding eligibility for effective dates of coverage under Medicare Parts A, B and D.		
Date (MM/DD/CCYY)	Subscriber signature (Required)	Telephone (   )



## 1003 Premium Payment

Annuitant premium payments are made through one of the following methods:

**Employer Paid Annuitant** - Premiums are paid to ETF by the employer when the employer pays any portion of the premium for the annuitant.

**Annuity Deduction** - Premiums are paid from a monthly retirement or disability annuity if the annuity is sufficient to cover the entire premium.

**Direct Pay** - When the annuity is not sufficient to cover the entire premium, the health plan will directly bill the annuitant, and the annuitant will pay premiums directly to the health plan.

**Group Life Insurance Conversion** - This program, governed by Wis. Stat. § 40.72 (4r) and Wis. Admin. Code ETF 60.60, allows eligible employees to convert their group life insurance to pay health insurance premiums. For more information, refer to the *Converting Your Group Life Insurance to Pay Health or Long-Term Care Insurance Premiums* brochure (ET-2325).

## 1004 Completing Employer Verification of Health Insurance Coverage

An *Employer Verification of Health Insurance Coverage* (ET-4814) must be submitted to ETF for each employee regardless of whether the employee plans to continue health coverage after retirement. The form is required, even when the employer is paying all or part of an annuitant's monthly health premium. An insured employee receives the form with the retirement application from ETF. The form is also required for a surviving spouse/dependent of a deceased insured employee or employer-paid annuitant. The employee or survivor completes the top portion of the form and submits to the employer.

Employer Instructions - Complete the Employer Section of the form reflecting the coverage as of the date employment terminates:

1. Check the appropriate box for coverage verification:
  - a. Coverage verified is in effect; or
  - b. Coverage verified is not yet in effect but employee has submitted a health insurance application to change coverage. (Advise employee to submit a *Health Insurance Application/Change Form* (ET-2301) with the *Employer Verification of Health Insurance Coverage* form if coverage will change when coverage as an active employee ceases.)
2. Plan - The name of the health plan.
3. Five-digit Group Number - The first digit of the group number is 7, followed by the four-digits preceding the "-000" in your EIN (e.g., 79999).

4. Coverage Type - Indicate Single **or** Family coverage.
5. Monthly Premium Rate - Enter the full monthly premium rate – TOTAL OF EMPLOYEE AND EMPLOYER CONTRIBUTIONS. Refer to the current *It's Your Choice booklet* (ET-2128).
6. Enter the month, day (the last day of the month) and year through which health insurance coverage is paid as an active employee.
7. Indicate whether premiums will be paid by the employer after termination: "Yes" **or** "No."
8. Name of Employer.
9. Employer Number - The number given to employers beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-9999-000).
10. Date - Enter the current date.
11. Signature of Employer Representative - Signature of the employer representative completing the form.
12. Telephone Number - The telephone number of the employer representative who completed the form.

Return the top two plies to the employee. Keep the bottom ply for your records. The employee must submit the form to ETF after completing the employee portion. A sample of the Employer Verification of Health Insurance Coverage form appears at the end of this subchapter.



**Verification of Health Insurance Coverage and Local Employer Paid Annuitant Transfer Report**

Wisconsin Department of Employee Trust Funds  
 801 W. Badger Road  
 Madison, WI 53707-7931  
 1-877-533-5020 (toll-free)  
 Fax: 608-267-4549  
[etf.wi.gov](http://etf.wi.gov)

See Instructions on Page 2 for assistance. Please print.			
<b>Part A: Employer Verification of Health Insurance Coverage</b>			
Health plan:			
Monthly premium: \$	Coverage type: <input type="checkbox"/> Single <input type="checkbox"/> Family		
Coverage as an <i>active employee</i> ends on? (mm/dd/ccyy) _____			
Will premiums be paid by the <i>employer</i> after termination/retirement?: <input type="checkbox"/> Yes <input type="checkbox"/> No			
If <b>Yes</b> , employer must complete and submit Section C of this form at least two months prior to the date when the employer contribution for premiums will end.			
Note: To qualify as a local employer paid annuitant, the employer <i>must</i> pay a portion of the total premium due.			
Employer number: 69-036-	Employer name:		
Signature of employer representative:	Date: (mm/dd/ccyy)	Phone number:	
<b>Part B: Employee Information</b>			
I wish to continue my health insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No (If <b>no</b> , please note that currently there are <b>no</b> re-enrollment opportunities for the Wisconsin Public Employer's Group Health Insurance Program.)			
Employee name:		Employee SSN: _____	
		DOB: (mm/dd/ccyy) _____	
Address: Street No.	City	State	ZIP Code
Spouse/domestic partner/dependent/survivor name (last, first, MI)		SSN: _____	
		DOB (mm/dd/ccyy) _____	
Signature of employee:		Date: (mm/dd/ccyy)	
<b>Part C: Transfer Report</b> (Local paid annuitant <b>no longer</b> receiving employer contributions.)			
Employee name: _____		SSN/Member ID: _____	
DOB: _____ (mm/dd/ccyy)		Gender: ____ Health plan: _____	
Date coverage ends (employer contributions to premiums cease): _____ (mm/dd/ccyy)			

*Employer: Keep a copy of this form for your records and make a copy for your employee.*

